THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-5445.M5

MDR Tracking Number: M5-05-1246-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-27-04.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 12-17-03 through 12-26-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the chiropractic manipulation (98942 and 98941) for dates of service 12-29-03 through 8-13-04 was not medically necessary.

On 3-1-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Neither the carrier nor the requestor provided EOB's for CPT code 98941 for dates of service 5-3-04 and 7-12-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. **Recommend reimbursement of $83.76 ($41.88 X 2 DOS).**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 5-3-04 and 7-12-04 as outlined above in this dispute.

This Order is hereby issued this 17th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

February 23, 2005 **Amended Letter 03/01/05**

Program Administrator
Medical Review Division

Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1246-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 31 year-old male injured his back, left side and left elbow on ___ when he fell off a drilling rig approximately 15 feet, landing on his left side. X-rays showed no fractures. He has been treated with medication, therapy and work hardening.

Requested Service(s)

Chiropractic manipulation (98942), chiropractic manipulation (98941) for dates of service 12/29/03 through 08/13/04

Decision

It is determined that there is no medical necessity for the chiropractic manipulation (98942) and chiropractic manipulation (98941) for dates of service 12/29/03 through 08/13/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was injured when he fell from a drilling rig and landed on his left side. He was treated with approximately six months of therapy and an eight-week work hardening program. He was released back to work on 01/05/01 with medium duty restrictions and a 9% maximum medical improvement rating. His next evaluation was 3 years later on 12/17/03. To receive continued treatment for his worker’s compensation injury, there must be a direct link of his

current complaints to his original injury on ___. The medical record documentation does not give sufficient indication that there is a direct link between his current complaints and the original injury. Therefore, the chiropractic manipulation (98942) and chiropractic manipulation (98941) for dates of service 12/29/03 through 08/13/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1246-01

Information Submitted by Requestor:

- Summary of Disputes
- Treatment Notes
- Claims

Information Submitted by Respondent:

- Respondent Position
- Peer Review
- Emergency Room Notes
- Progress Notes
- Work Hardening
- Impairment Rating
- Orthopedic Notes
- Patient's Letter
- Requests of Reconsideration